

Health Care Law

Mid-Atlantic Ethics Committee Newsletter

University of Maryland Francis King Carey School of Law Year 2015

Mid-Atlantic Ethics Committee
Newsletter, Summer 2015

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MID-ATLANTIC ETHICS COMMITTEE

NEWSLETTER

A Newsletter for Ethics Committee Members in Maryland, The District of Columbia and Virginia
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Summer 2015

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The *Mid-Atlantic Ethics Committee Newsletter* is a publication of the Maryland Health Care Ethics Committee Network, an initiative of the University of Maryland Francis King Carey School of Law's Law & Health Care Program. The Newsletter combines educational articles with timely information about bioethics activities. Each issue includes a feature article, a Calendar of upcoming events, and a case presentation and commentary by local experts in bioethics, law, medicine, nursing, or related disciplines.

Diane E. Hoffmann, JD, MS
Editor

ETHICS AND EMS

Emergency Medical Technicians (EMTs) respond to a 9-1-1 call regarding an elderly man who has lost consciousness in a restaurant. The man regains consciousness and refuses transport to the hospital unless the ambulance team transports him to a particular hospital, which is not the hospital they are authorized to take him to. Should the EMTs accommodate his preference?

While most cases that come to ethics committees seem to take place after a patient has been admitted to a particular hospital unit, emergency medical services (EMS) personnel are no strangers to ethical conflicts. EMS services include care provided in the field by emergency medical technicians (EMTs) and the care provided by hospital emergency department (ED) staff. Ethical issues in the EMS setting are influenced by what's happening in hospitals. When hospital inpatient settings are backed



up, discharge from the ED to other hospital units slows, contributing to ED crowding. Use of the ED as a source of primary care rather than emergency care compounds ED crowding. The hospital ED is unique compared to other hospital departments. Because it has no firm occupancy limits and patients needing emergent treatment can't be turned away once they arrive, ED crowding creates ethical concerns about safe and fair treatment of patients. ED staff often treat overflow patients in hallways and other makeshift areas, raising concerns about inappropriate staff-to-patient ratios, inadequate equipment to meet patient care needs, and privacy violations.

One approach to remedy ED crowding is having EMS personnel re-route patients from one ED to another. Geiderman and colleagues (2015) review the practice and moral implications of "ambulance diversion" in a recent article in the *American Journal of Emergency Medicine*. The authors recognize the challenge in emergency medicine of meeting competing obligations to respect individual autonomy while providing just and efficient emergency medical services to a community. Because ambulance diversion singles out sicker patients (i.e., patients not arriving by ambulance can still access EDs), it raises justice concerns. Diverted patients face increased transport times and may end up in hospitals lacking specialty services they may need. EMS systems that have greatly restricted ambulance diversion have

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Law & Health Care Program
University of Maryland
Francis King Carey School of Law
500 West Baltimore Street
Baltimore, MD 21201
410-706-7191

Diane E. Hoffmann, JD, MS, Editor
Anita J. Tarzian, PhD, RN,
Co-Editor

Contributing Editors:
Joseph A. Carrese, MD, MPH
Associate Professor of Medicine
Johns Hopkins University

Brian H. Childs, PhD
Community Professor of Bioethics,
Mercer University School of
Medicine, Savannah, GA

Evan DeRenzo, PhD
Ethics Consultant
Center for Ethics
Washington Hospital Center

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U.S.U.H.S. Department of
Psychiatry

Laurie Lyckholm, MD
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Medicine and Professor of
Bioethics and Humanities,
Virginia Commonwealth
School of Medicine

Jack Schwartz, JD
Adjunct Faculty
University of Maryland
Francis King Carey School of
Law

Henry Silverman, MD, MA
Professor of Medicine
University of Maryland

Comments to:
MHECN@law.umaryland.edu

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Ethics and EMS

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demonstrated reduced ambulance transport times, reduced ED throughput and lengths of stay, improved quality of care, reduced ED volumes, and improved relationships with EMS providers and hospital staff (Geiderman, et al., 2015).

In Maryland, coordination between EDs and EMS providers is overseen by the Maryland Institute for Emergency Medical Services Systems (MIEMSS). Since 1993, MIEMSS has been governed by the State Emergency Medical Services Board, which runs Maryland's emergency medical systems plan. This plan identifies trauma facility criteria and guidelines for providing emergency medical services. It also implements strategies to improve communication and transportation surrounding emergency medical services.

Maryland is unique in its emergency medical services structure. The Emergency Medical Resource Center (EMRC) operates the MIEMSS Statewide Communications System (SYSCOM), which provides 24/7 communications among ambulances, medevac helicopters, dispatch centers, hospital emergency departments, trauma centers, specialty referral centers, and law enforcement. SYSCOM has been cited as a model for the nation in coordinating emergency medical services. A unique component of this communications system is Maryland's real-time computerized monitoring system of hospital and EMS system status throughout the state. In 2009 MIEMSS adopted an upgraded software version of Healthcare (HC) Standard for its statewide EMS communications system. This combines the County Hospital Alert Tracking System (CHATS), Facility Resource Emergency Database (FRED), the County Hospital Request System



(CHRS), and the Healthcare (HC) Patient Tracking System. The CHATS component of the HC Standard provides up-to-date hospital diversion and county alert statuses. The FRED component allows for real-time tracking of data points requested by the state, such as medications, supplies, bed availability, and daily hospital Influenza Like Illness (ILI) numbers (Maryland EMS News, 2010). The Patient Tracking feature of HC Standard combines barcode scanning and GPS location services to track patients in the EMS system.

This complex system gives Maryland an advantage in ensuring that patients needing emergency medical response receive efficient and equitable access to EDs that can serve their needs. Wen and Sharfstein (May 7, 2015) give examples of this during the Baltimore riots in April. For a more routine example: a patient having a heart attack who needs a procedure to unblock an artery would receive priority access to a hospital where this intervention can be performed based on the information available in the HC Standard system. Authorized users in Maryland hospitals can request changes online to their status through CHRS (e.g., ED ambulance diversion or "re-route") without having to speak to an EMRC operator.

HOSPITAL ALERTS IMPACTING EMERGENCY MEDICAL RESPONSE

Red Alert: The hospital has no ECG monitored beds available. ECG monitored bed is defined as any adult in-patient critical care bed, including specialty critical care units and telemetry beds.

Yellow Alert: The emergency department temporarily requests that it receive absolutely no patients in need of urgent medical care.

Mini-Disaster: The emergency department reports that its facility has, in effect, suspended operation and can receive absolutely no patients due to a situation such as a power- outage, fire, gas leak, bomb scare, etc.

Blue Alert: Overrides all alerts, except the Mini-Disaster Alert, causing all patients, from within that jurisdiction, to be transported to the closest facility appropriate for the patient's medical needs due to extraordinary situations temporarily taxing the EMS system.

See <http://www.miemss.org> to view region-specific guidelines for each alert across Maryland hospitals.

If approved, the hospital's status is updated in CHATS and the request is communicated through the medical channel radio communications system that directs EMS providers in the field (<http://www.miemss.org/>). However, ambulance diversion must be based on objective and stringent criteria in order to meet the ethical obligations to minimize risks, maximize benefits, and be fair to all patients. Sometimes individual autonomy is sacrificed for the greater good, such as when a patient requests that he or she be transported to a preferred hospital.

State EMS Medical Director Dr. Rick Alcorta and his colleagues handle ED re-route requests routinely. Approving or declining such requests involves a complex balancing of risks and benefits at the individual hospital level and across hospitals, as well as considering demands from neighboring states (American College of Emergency Physicians, 1999). Hospitals are expected to have contingency plans and protocols in place to avoid having to request EMS diversion for foreseeable

situations, such as hospital-wide electronic medical record failure, or ED crowding caused by patient discharge delays. In general, emergency medicine recognizes a duty to treat patients for whom a therapeutic relationship has already been established, and this justifies ED diversion in some circumstances. But this should be the exception, not the rule, and even when justified, exceptions may need to be granted, such as for patients whose chances of survival would be diminished if they were re-routed to another hospital.

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MULTI-SOCIETY GUIDANCE ON RESPONDING TO MEDICALLY INAPPROPRIATE TREATMENT REQUESTS

The American Thoracic Society (ATS), American Association for Critical Care Nurses (AACN), American College of Chest Physicians (ACCP), European Society for Intensive Care Medicine (ESICM), and the Society of Critical Care Medicine (SCCM) recently endorsed a joint policy statement guiding clinicians to prevent and manage disputes in patients with advanced critical illness who request (or whose surrogate requests) potentially inappropriate treatments. Recommendations include the following:

1. Institutions should implement strategies to prevent intractable treatment conflicts, including proactive communication and early involvement of expert consultants.
2. The term “potentially inappropriate” should be used, rather than futile, to describe treatments that have at least some chance of accomplishing the effect sought by the patient, but clinicians believe that competing ethical considerations justify not providing them. Clinicians should explain and advocate for the treatment plan they believe is appropriate. Conflicts regarding potentially inappropriate treatments that remain intractable despite intensive communication and negotiation should be managed by a fair process of conflict resolution; this process should include hospital review, attempts to find a willing provider at another institution, and opportunity for external review of decisions. When time pressures make it infeasible to complete all steps of the conflict resolution process and clinicians have a high degree of certainty that the requested treatment is outside accepted practice, they should seek procedural oversight to the extent allowed by the clinical situation and need not provide the requested treatment.
3. Use of the term “futile” should be restricted to the rare situations in which surrogates request interventions that simply cannot accomplish their intended physiologic goal. Clinicians should not provide futile interventions.
4. The medical profession should lead public engagement efforts and advocate for policies and legislation about when life-prolonging technologies should not be used.

Of note, the SCCM and ATS are working on a policy statement regarding shared decision-making in the ICU. That policy statement, currently in the review process, is anticipated to be available by 2016.

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The Maryland Healthcare Ethics Committee Network (MHECN) is a membership organization, established by the Law and Health Care Program at the University of Maryland Francis King Carey School of Law. The purpose of MHECN is to facilitate and enhance ethical reflection in all aspects of decision making in health care settings by supporting and providing informational and educational resources to ethics committees serving health care institutions in the state of Maryland. The Network attempts to achieve this goal by:

- Serving as a resource to ethics committees as they investigate ethical dilemmas within their institution and as they strive to assist their institution act consistently with its mission statement;
- Fostering communication and information sharing among Network members;
- Providing educational programs for ethics committee members, other healthcare providers, and members of the general public on ethical issues in health care; and
- Conducting research to improve the functioning of ethics committees and ultimately the care of patients in Maryland.

MHECN appreciates the support of its individual and institutional members. MHECN also welcomes support from affiliate members who provide additional financial support.

UPDATES FROM THE AMERICAN SOCIETY FOR BIOETHICS & HUMANITIES (ASBH)

CODE OF ETHICS AND PROFESSIONAL RESPONSIBILITIES FOR HEALTH CARE ETHICS CONSULTANTS ADOPTED

The American Society for Bioethics and Humanities (ASBH) has adopted the first Code of Ethics for Healthcare Ethics Consultants. Below is the Code Preface and seven responsibility statements. To view the interpretive paragraphs for each Code responsibility, visit ASBH's website (<http://www.asbh.org> – click on Publications). For additional interpretations of each Code element, see Tarzian, A.J., Wocial, L.D. and the ASBH Clinical Ethics Consultation Affairs committee (2015). A code of ethics for healthcare ethics consultants: Journey to the present and implications for the field. *American Journal of Bioethics*, 15(5), 38-51.

PREFACE

This statement sets out the core ethical responsibilities of individuals performing health care ethics consultation (HCEC)—specifically, clinical ethics consultation, a subset of HCEC. It does not explicitly address the ethical obligations for the range of additional ethics services that health care ethics (HCE) consultants may provide for an organization. Clinical ethics consultation (CEC) represents a subset of the activities performed by HCE consultants.

HCEC is “a set of services provided by an individual or group in response to questions from patients, families, surrogates, health care professionals, or other involved parties who seek to resolve uncertainty or conflict regarding value-laden concerns that emerge in health care” (ASBH, 2011). Ethics consultation seeks to identify and support the appropriate decision-maker(s) and ethically sound decision-making by facilitating communication among key stakeholders, fostering understanding, clarifying and analyzing ethical issues, and including justifications when recommendations are provided. It addresses the ethical concerns of persons involved in health care decision-making and health care delivery including patients, family members, health care providers, institutional leaders, and those who set guidelines and create policies.

PROFESSIONAL RESPONSIBILITIES

1. Be Competent. HCE consultants should practice in a manner consistent with professional HCEC standards.
2. Preserve integrity. HCE consultants should consistently act with integrity in the performance of their HCEC role.
3. Manage conflicts of interest and obligation. HCE consultants should anticipate and identify conflicts of interest and obligation and manage them appropriately.
4. Respect privacy and maintain confidentiality. HCE consultants should protect private information obtained during HCEC, handling such information in accordance with standards of ethics, law, and organizational policy.
5. Contribute to the field. HCE consultants should participate in the advancement of HCEC.
6. Communicate Responsibly. When communicating in the public arena (including social media), HCE consultants should clarify whether they are acting in their HCEC role, and should communicate in a manner consistent with the norms and obligations of the profession.
7. Promote just health care within HCEC. HCE consultants should work with other health care professionals to reduce disparities, discrimination and inequities when providing consultations.

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PILOT PROJECT ESTABLISHES FIRST PHASE OF METHOD TO EVALUATE CLINICAL ETHICS CONSULTANTS' COMPETENCY

ASBH's Quality Attestation Presidential Task Force (QAPTF) completed the first phase of a pilot project to evaluate the competency of clinical ethics (CE) consultants. Of 82 CE consultants who offered to take part in the initial pilot evaluation, 40 were randomly selected to submit a portfolio containing specified information (see BOX p. 6). Of

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those, 23 submitted portfolios, which were evaluated by the QAPTF members using evaluation tools developed for this purpose. The portfolio review was developed to determine who would be eligible to take part in the second step of quality attestation—an interview. Of the 23 portfolios reviewed, the Task Force identified 20 individuals who are eligible to progress to the interview stage. This stage of the attestation process is currently in development. The Josiah Macy Jr. Foundation and The Greenwall Foundation have provided funding for this project.

QAPTF PORTFOLIO CONTENTS (Kodish, Fins, et al., 2013)

- Evidence of education, training, and experience related to CEC
- Statement of CEC philosophy
- Three letters of evaluation from individuals knowledgeable about the candidate's CEC activities
- Six case discussions of consultations in which the candidate acted as lead or co-lead consultant and authored or co-authored the chart note/consult documentation
 - evidence of competency can be demonstrated using sources such as redacted consultation chart notes that include the case narrative, synopsis of relevant ethical issues, ethical analysis, and recommendation(s), and minutes of a case conference or ethics committee meeting
- Six one-page descriptions of additional cases that evidence CEC experience in a wide range of clinical settings and/or with a wide range of ethical issues

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Kodish, E. & Fins, J.J., et al. (2013). Quality attestation for ethics consultants: A two-step model from the American Society for Bioethics and Humanities, Hastings Center Report, September-October, 26-36.

CASE PRESENTATION

One of the regular features of this Newsletter is the presentation of a case considered by an ethics committee and an analysis of the ethical issues involved. Readers are both encouraged to comment on the case or analysis and to submit other cases that their ethics committee has dealt with. In all cases, identifying information about patients and others in the case should only be provided with the permission of the patient. Unless otherwise indicated, our policy is not to identify the submitter or institution. We may also change facts to protect confidentiality. Cases and comments should be sent to MHECN@law.umaryland.edu, or MHECN, Law & Health Care Program, University of Maryland Francis King Carey School of Law, 500 W. Baltimore St., Baltimore, MD 21201.

ETHICS CONSULTATION REQUEST FROM A PEDIATRIC CLINIC

Dr. Cantor, the head of an inner city pediatric practice, is considering developing a policy regarding parents who refuse to vaccinate their children. The practice is situated in a low-income, inner-city neighborhood. Reasons for parental vaccine refusal mostly involve distrust and poor understanding of vaccine safety. Clinicians in the practice have differing opinions

about their obligations to their patient population. Some believe they have an obligation to protect children who are not vaccinated based on parental refusal, even if it means discharging patients from the clinic if the parent doesn't agree to medically-recommended vaccines for their child. Other clinicians believe they should not abandon their patients based on parental vaccine refusal, as most of the families accessing the practice are challenged by poverty, joblessness, low health literacy, and poor access

to pediatric health care services and would suffer more harm from such a hard line position. Dr. Cantor requests an ethics consultation from the University medical center with which the pediatric practice is affiliated for help. Should they develop a policy, and what is a reasonable approach in balancing competing obligations to this vulnerable population?

COMMENTS FROM A PEDIATRICIAN AND BIOETHICIST

Vaccines are truly a public health

success story. In the United States, morbidity and mortality from vaccine-preventable diseases has sharply declined. A child born in 2015 can be protected from the following 13 diseases by the time he or she is 18 months old.¹

- Hepatitis B, which can lead to liver failure and/or cancer
- Diphtheria, causing respiratory illness and sometimes death from asphyxiation
- Pertussis (whooping cough), causing prolonged coughing spasms, occasionally fatal in unvaccinated infants
- Tetanus, (“lock-jaw”), producing weeks of severe, painful muscle contractions
- Polio, which caused epidemics of paralysis in children as recently as the 1950s
- Rotavirus, causing severe, dehydrating diarrhea
- Haemophilus influenza type b, causing meningitis, pneumonia, and epiglottitis
- Pneumococcus strains, causing pneumonia, meningitis, and ear infections
- Measles, causing high fevers, pneumonia and encephalitis
- Mumps, causing high fevers and painfully swollen salivary glands, occasionally causing encephalitis, deafness, and male sterility,
- Rubella (German measles) causing fevers, rash, joint swelling, pain, with serious birth defects and brain damage in the fetus if contracted when pregnant
- Chickenpox, though often relatively mild, can lead to pneumonia, and serious infections of skin, brain and heart muscle
- Influenza, often causing severe disease and occasionally death in young children

No parent should want their child to experience these awful diseases unnecessarily. However, few 21st century parents (and recently trained physicians) have any first hand experience with them. As an unintended consequence, some parents are hesitant or refuse to have their children immunized—focusing not on the risk of disease, but on the rare, but real vaccine side effects and/or unfounded risks circulated throughout the Internet and other media.

The unimmunized pose a risk to themselves and to the community at large. Some groups of people cannot be vaccinated, such as young infants and persons with certain medical conditions. Additionally, not all who are vaccinated will develop protective immunity. All these groups depend on “herd immunity” – the inability of a disease to spread in a highly vaccinated community.² Herd immunity only works if a large proportion of the community is immunized. When the number of immunized persons drops, the risk of an epidemic rises.²

If unimmunized persons travel to places where vaccine-preventable illnesses are endemic, they can become infected, bringing the disease home with them. Because vaccine-refusing families tend to be clustered in certain communities, a mini-epidemic may result in that community, then spread to vulnerable others.³

Despite these dangers, parents are allowed to refuse childhood vaccinations because, absent an epidemic, a failure to vaccinate does not pose an immediate risk to the child’s life or health. Unfortunately, the child remains vulnerable to contracting devastating illnesses.

All 50 states require proof of age-appropriate immunization to attend school. Only home-schooled children

are exempt. Medical exemptions are allowed in every state and 48 states also permit some combination of religious/philosophic exemptions.⁴ The difficulty in obtaining these exemptions varies widely from state to state. Unsurprisingly, the rate of non-medical exemptions is higher in states with lax exemption requirements. Standardizing the requirements for non-medical exemptions may be one way of improving vaccination rates.⁵

Vaccine policies created by physicians and health care institutions must balance patient/parent autonomy while protecting the health of the public, including vulnerable patients and staff. Parents who refuse vaccines are problematic for pediatricians. Apart from leaving the child exposed to preventable illness, the parent’s refusal indicates some level of distrust in the physician. Parent-physician trust is essential to pediatric practice. Although the child is the pediatrician’s patient, the physician must persuade a third party – the parent or guardian – to agree to and implement a treatment plan. When the physician’s advice is refused in an area as important as vaccination, it rightly calls into question the viability of the parent-pediatrician relationship.

Vaccine hesitant or refusing parents are usually non-minority and well educated. Because they are well educated, it is particularly frustrating when they choose to believe in scientifically unsupported theories and claims about vaccine dangers, instead of the pediatrician’s guidance. Parents believe their knowledge to be superior to that of the physician in this area. They are often aware of the proven risks of immunization, and minimize the danger of vaccine-preventable illness. In their opinion, the remote likelihood that their child will suffer a

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Case Presentation

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real side effect, when added to that of the unverified risks, outweighs the risk of the disease.

However, the parents in the case are not typical. Described as low income with low health literacy, we have no information as to why they are refusing the vaccines. Are they suspicious of vaccination only, or is a general distrust of the providers manifesting as vaccine refusal?

As physicians, we must be sensitive to the diverse needs of our families and provide them with understandable information. Do the parents in this case understand the vaccine information sheets? Do they need someone to explain it to them? Do they have beliefs and misconceptions about vaccines? What are they? The most powerful “education” can be the physician’s admission that his or her own family is vaccinated, that office staff members’ families are vaccinated. Personal stories of other parents who were vaccine hesitant can also be persuasive.

If the vaccine refusal is an indication of a global mistrust, the practice should determine why families are perceiving it to be untrustworthy. Does everyone in the practice treat the families with respect, from the clinic receptionists to physicians? The population described, especially if African American, may have deep-seated mistrust and suspicion of the motives of health care providers due to vicarious and personal experiences of discrimination.⁶ How do the providers talk about the families among themselves? Insincere behavior is easy to spot. Do providers make eye contact with parents? Do they ask all adults what they wish to be called before presuming to use their first name or even the ubiquitous “Mom” or “Dad”? Do they smile and speak in a friendly and courteous tone? All these behaviors convey respect and

their absence may signal unfeeling indifference.^{7,8}

Any policy should keep in mind that as pediatricians, our decisions should be made to avoid jeopardizing the child’s future medical care. First and foremost should come respectful empathy and relevant education to correct any misconceptions about vaccination. To protect vulnerable patients from the unimmunized, it may be necessary to create a separate waiting area. Dismissing families from the practice is a last resort, if refusals extend to other areas, signaling a breakdown in the relationship.⁹ It still does not achieve the goal of protecting the child against disease and it will likely make it difficult for the parent to find alternate health care.

*Kathryn L. Moseley, MD, MPH
Assistant Professor of Pediatrics
University of Michigan
Medical School*

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RESPONSE FROM A PUBLIC HEALTH LAWYER

Factors leading a parent to refuse vaccinations for their children often include the fear of adverse side effects, an incomplete understanding of vaccine risks and benefits, and a misconception of how immunization works. Fear, misunderstanding, and misconception may be addressed through consultation and advice with a pediatrician or other health educator, but what’s one to do when a parent continues to refuse a medically recommended vaccination based on his or her religious or personal belief? It is unfortunate that pediatricians face this dilemma and instituting a policy, such as the one described in the case study, to discharge a patient whose parent ultimately refuses vaccinations puts the pediatrician

between the metaphorical rock (i.e., denying an innocent patient future care and services) and a hard place (i.e., risking the well-being of other patients too young or medically unable to be vaccinated). Neither result of the discharge policy appears to be beneficial to either the individual patients or to public health.

Instead of relying on pediatricians to confront the parental refusal issue we should concentrate on broader legislative policy solutions that would increase vaccination rates for all children. This would allow pediatricians to focus on the care of their patients. The legal history of compulsory immunizations and recent legislative action on personal belief exemptions for vaccination requirements show the potential for a wider public response to parental refusal.

Controlling disease with childhood immunizations is one of the greatest public health achievements of the 20th Century. Beginning in the latter half of the 19th Century states started using their police powers to mandate vaccinations for school attendance (e.g., Massachusetts in 1855, New York in 1862, Connecticut in 1872, and Pennsylvania in 1895). Today, every state has some form of legal requirement for children to be vaccinated before entering large group settings, whether it be day care, pre-school, public or private schools, or university. Some states even go beyond linking compulsory immunization to group settings. For example, according to one North Carolina statute, N.C. Gen. Stat. §§ 130A-152, every child in the state is required to be immunized against diphtheria, tetanus, whooping cough and other diseases.

In 1905 the U.S. Supreme Court upheld the states' authority to enact compulsory vaccination laws. In *Jacobson v. Massachusetts*, 197 U.S. 11 (1905), the court concluded that

a mandatory vaccination does not violate an individual's personal liberty and that "[liberty] does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good." However, compulsory immunizations for school attendance did not remain absolute as states began to permit exemptions from the requirements for children whose parents object to vaccinations on religious grounds. While the U.S. Supreme Court has not decided whether such mandates infringe on religious freedom, in *Prince v. Massachusetts*, 321 U.S. 158 (1944), a case centered on religious freedom and child labor laws, the court commented that "[t]he right to practice religion freely does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death." The Second Court of Appeals reiterated this point earlier this year in *Phillips v. City of New York*, 775 F.3d 538, 542 (2d Cir. 2015) when it held that New York's mandatory school vaccination requirements do not violate the Free Exercise Clause and declared that the state could require all public school children to be vaccinated if it so chose. In other words, allowing religious exemptions is at the discretion of the state.

Today, only two states, West Virginia and Mississippi, refuse to allow any kind of non-medical exemption. Many states have chosen to go beyond religious exemptions and allow parents to refuse vaccinations when the parent has a philosophical or personal belief against immunization. Approximately twenty states currently allow personal belief exemptions. Supporters of personal belief exemptions often cite parental rights as a basis for the exemptions while others question the number of required vaccinations

and try to link the requirements to pharmaceutical company profiteering.

Over the past few years we've seen a dramatic increase in the number of parents refusing compulsory vaccinations. For example, between 2009 and 2014 the percentage of children entering kindergarten in Michigan who have a non-medical exemption has increased from 3.8% to 5.4%. In Maryland the rate has remained low, increasing over the same time period from 0.5% to 0.7%. These are statewide numbers however, and in each state there are pockets of communities where the exemption rates for children are much, much higher. One of the reasons for the increased rates of non-medical exemptions is the ease by which it takes to get one. Many states simply allow a parent to sign a form declaring the presence of a religious or personal objection to vaccines. Some states even allow parents to have objections to certain vaccines rather than all of them. Overall, states with personal belief exemptions have 2.5 times the rate of parental refusal than states with only religious exemptions. With the increasing number of parents refusing vaccinations the recent measles outbreak in California should have been little surprise.

While troubling in its nature and scope, the measles outbreak has resulted in organized, legislative efforts to counter parent refusal and non-medical exemptions. During the past legislative season, several states proposed to eliminate personal belief exemptions, reduce the ease of obtaining the exemption, or make information about the exemption rates more readily available. Just this past May, Vermont's legislature passed a bill to remove that state's personal belief exemption while efforts continue in California to eliminate its personal belief exemption. A bill

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Case Presentation

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in Minnesota would require parents seeking a non-medical exemption to submit a statement from a physician that they received advice on the benefits and risks of immunization. Similar physician advice statements were enacted by California and Washington a couple of years ago. Bills in Texas and other states would require that immunization rates for schools or school districts be made publicly available while in Missouri proposed legislation would notify parents whenever an unvaccinated child enrolled in school. Finally, legislative attempts to allow non-medical exemptions in West Virginia and Mississippi, the only two states currently without religious or personal belief exemptions, were defeated.

The recent legislative efforts to curb personal belief exemptions will hopefully give some comfort to pediatricians who face the challenge of parents refusing vaccinations. Amending the exemption laws would have a greater reach and increase

vaccination rates for all children than individual office policies that would simply kick the can down the road. It is clear that state legislatures have the authority to address parental refusal of vaccinations and when they end up dealing with the issue it is important for pediatricians and others to give them the reason to make change.

Andy Baker-White, JD, MPH

Associate Director

The Network for Public Health Law

– Mid-States Region

Ann Arbor, MI

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CALENDAR OF EVENTS

AUGUST

3-7

28th Annual Summer Seminar in Health Care Ethics, sponsored by the Department of Bioethics & Humanities at the University of Washington School of Medicine, Seattle, WA. For more information, visit www.uwcme.org

7-8

Transplant Ethics: Dilemmas and Discussions, sponsored by the Mayo Clinic College of Medicine. Minneapolis, MN. <http://ce.mayo.edu> (search "transplant").

13-16

Workshop in Clinical Ethics Mediation, Sponsored by the University of Pennsylvania Department of Medical Ethics and Health Policy, Philadelphia, PA, For more information, visit <http://medicaethics.med.upenn.edu/education/master-of-bioethics-mbe/clinical-ethics-mediation>.

SEPTEMBER

18

Civility and Clinical Ethics in the 21st Century, 5th Annual Judy Levy Ethics Workshop sponsored by Social Work at the Kennedy Krieger Institute, Baltimore, MD. For more information, contact Linda Friend, 443-923-2802, friend@kenedykrieger.org.

CALENDAR OF EVENTS

18

Saying No: Exploring the Ethical Dimensions of Refusals in Healthcare. 2nd Annual Symposium of the Clinical Ethics Network of North Carolina (CENNC). For more information, visit <http://www.mahec.net> (click on "Continuing Education," then "View Course Calendar").

24-25

Fifth Annual Western Michigan University Medical Humanities Conference, Kalamazoo, MI. For more information, visit www.wmich.edu/medicalhumanities.

25-27

Health Care Ethics & the Humanities in Medicine, sponsored by the University of Pittsburgh Consortium Ethics Program. For more information visit: <http://www.pitt.edu/~cep/>.

30 – October 2

Integrity of Creation: Climate Change. Sponsored by Duquesne University, Pittsburgh, PA. For more information, visit <http://www.duq.edu/research/integrity-of-creation-conference---climate-change>.

OCTOBER

15-16

International Neuroethics Society's Annual Meeting, Chicago, IL. For more information, visit <http://www.neuroethicssociety.org/>.

22-25

17th Annual Meeting of the American Society for Bioethics and Humanities. Houston, TX. For more information, visit <http://www.asbh.org>

NOVEMBER

2

Second Annual Interprofessional Forum on Ethics and Religion in Health Care – Maintaining Dignity, Respect and Familial Cohesion as our Loved Ones and Patients Age. Sponsored by the Institute for Jewish Continuity and the University of Maryland Schools of Dentistry, Medicine, Law (MHECN), Nursing, Pharmacy, and Social Work. University of Maryland's SMC Campus Center, 621 W. Lombard St., Baltimore, MD. For more information, visit <http://www.law.umaryland.edu/mhecn> (click on Conferences).

5-6

Professional and Shared Decision-making: Back to the Future. Kaiser Permanente National Bioethics Symposium. For more information, visit <http://www.kpsymposia.com>.

6

Eighth Annual Pediatric Bioethics Conference, sponsored by Wolfson Children's Hospital, in partnership with the Florida Blue Center for Ethics at the University of North Florida and the Florida Bioethics Network, Jacksonville, FL. For more information, visit <http://fhn.med.miami.edu/>.

13-14

27th annual MacLean Conference on Clinical Medical Ethics, The University of Chicago Law School (1111 East 60th Street, Chicago, IL). For more information, visit http://macleanethics.uchicago.edu/events/maclean_conference/2015_conference_program/

The Johns Hopkins Berman Institute of Bioethics hosts bioethics seminars on the second and fourth Monday of each month from 12:15 PM to 1:30 PM. Lunch is provided. To receive emails of seminar speakers or for more information, contact Tracie Ugamoto at tugamoto@jhu.edu, 410-614-5550, or visit <http://www.bioethicsinstitute.org/education-training-2/seminar-series>.

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